Healthcare management and the decision-making process perspective: could a normative framework from stakeholder theory help?

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Abstract :

Healthcare appears to be a world of Evidence-Based Medicine and rational decisions. Seldom available, sufficient or relevant in view of human needs, scientific evidence do not address priorities when resources are more than ever globally insufficient to an increasingly voracious system. Literature shows than evidence are not sufficient while a wide range of “stakeholders” vie to influence the decision-making process.

We will be discussing the part "stakeholders" play in the decision-making process. Using the Integrative Social Contract Theory, we will be discussing "hypernorms" and unsolved dilemmas that exist within the Healthcare providing system. Using Philips works, we propose a normative and derivative approach of stakeholders' expectations in strategic management. We suggest that a framework that takes stakeholders' expectations –rather than simply their identities- into account, is a prerequisite to managing resource allocation in transparency and making sure that the efficiency requirements are acceptable for those stakeholders individually and collectively.

Key words :

Healthcare – stakeholders theory

Introduction

In 1946, the newly constituted United Nations Organization founded the World Health Organization. The preamble to the Constitution which came into force in 1948, defined health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity", a definition that is wide enough to include all aspects of human life, from well-being to deprivation. Creating such an organization addresses the morals values of human beings and makes the preservation of well-being a hypernorm within the community of nations. But good health is not only presented as a "real" human right or as an essential aspect of human welfare, it is also a prerequisite to sustaining economic and social development, with economic and social development sustaining health, thus giving health a wider collective systemic purpose (World Health Organization 2010).

The most well-known aspect of the larger healthcare system is curative medicine, known as the Health Care Provision System (HCPS). Although just one aspect of the "healthcare system"[1], it is the one on which all attention is focused. Historically dominated by normative ethics that date back to the origins of our civilisation (Hippocratic oath), it now represents between 10 and 14% of the GDP of developed countries. In such countries, individual solvency has been insured by mutual public or private insurance funds, very much akin to a "common resource pool". For years now, the issue of HCPS performance has been questioned (World Health Organization 2000), and the share of resources that are "disproportionately focusing on the narrow offer of specialized curative care", and "short term results" resulting in the "unregulated commercialization of health" has been exposed (World Health Organization 2008). The elements required to discuss ethics and business are brought together here, with preoccupations focusing on what has been called the "Tragedy of the Commons" (Harding 1968), which looks at solutions to manage it in a sustainable way (Ostrom 1999).

The HCPS appears to be a world of Evidence-Based Medicine and rational decisions, with scientific and technical information acting as a neutralizing force on diverging values (Heikkila & Gerlak 2005) in resource allocation. But scientific evidence is seldom available, sufficient, or relevant in view of human needs, and does not address priorities when resources are more than ever globally insufficient. In such cases it is difficult to escape the "messy unfolding of collective action" that turns policy-making into a "social drama" (Greenhalgh & Russell 2006). Literature shows that evidence is often nonexistent and underutilized (Innvaer et al. 2002) (Sorenson et al. 2008) while a wide range of "stakeholders" (Angell 1993) including policy-makers, manufacturers, healthcare professionals and patients themselves, vie to influence the decision-making process. As controversy appears to be a way

[1] Sanitation, water supply and education have been largely promoted by the WHO as a way of increasing the health status of the population, and preventing infectious diseases in particular {{90 Wilkinson, R.G. 2003}}, but these are not included in what is usually called “health expenses”.

of exploring alternatives out of restricted scientific evidence, or to reframe or make sense of such evidence (Callon et al. 2001), could "stakeholders" guide us towards more efficiency in what has become a major problem for developed countries: that of allocating limited resources within increasingly voracious HCPS systems?

Generally analysed under Stakeholder Theory the claim that healthcare is more of a necessity than products and services is a challenge that has begun to blur the line between managerial/organizational stakeholder theory and matters of public policy. We have risen to this challenge, knowing full well that business is now an integral part of the healthcare system, and widely preoccupied by the interactions between both sides of the line.

Sorenson and al. suggested that relevant "stakeholders" should be more involved in the decision-making process regarding the approval of new health technologies (Sorenson et al. 2008); the acceptance of stakeholders' such as providers and patient in particular being a decisive aspect in terms of putting decisions into practices within the healthcare system (Organisation for Economic Co-operation and Development 2005). The necessity to consider "stakeholders" for the part they can play as performance levers is consistent with the instrumental variation of the theory. As for profit and prosperity in business (Jensen 2010) (Jones 1995) (Thomas Donaldson & Preston 1995) (Sternberg 2000) the cooperation of all "stakeholders" must be obtained in order to reach HCPS value requirements (the length and quality of life of patients). Some have suggested that they should be ranked according to legitimacy, the urgency of the request or their ability to exert any form of power (Mitchell et al. 1997) since they can help achieve the organization's objectives through their influence (Freeman 1984).

But the use of the word "stakeholders" within medical-economics literature often used to mean an "influential group" or simply "concerned citizens" merely adds to the confusion. The instrumental approach presupposes pre-existing goals to be reached and "stakeholder" management must be a way of achieving those goals. How can such a system manage a "common resource pool" and address such hypernorms as human life and wellbeing?

For the past 10 years, we have been exploring the different medical fields (oncology, nephrology, geriatrics…) of the French HCPS, and as experts we have participated in several government agency and public policy assessment groups. Our research programme, designed to reveal the ins and outs of the organization's cost-benefits and the reasons why changes were not made in the past, came to the conclusion that institutional requirements simply could not be reached without a more appropriate managerial approach, because of the differing "stakeholder" perspectives and expectations.

We will be discussing "stakeholder" status (1) and the part "stakeholders" play in the decision-making process (2). Using the Integrative Social Contract Theory, we will be discussing the question of goals, "hypernorms" and unsolved dilemmas that exist within the "macrosocial contracts" that drive HCPS

organization. We believe that using the Stakeholder Theory framework should first define the goals that will structure the part played by shareholders when this theory is applied to business. (3) Using Philips works, we propose a normative and derivative approach of stakeholders' expectations in strategic management. We suggest that a framework that takes stakeholders' expectations –rather than simply their identities- into account, is a prerequisite to managing resource allocation in total transparency and making sure that the efficiency requirements within the decision-making process are acceptable.

1) When do stakeholders act simultaneously as "citizens" determining priorities, "levers of performance" and "beneficiaries"?

Considering "stakeholders" as "citizens" refers to a democratic process aimed at defining those goals. The use of the term in the socio-political context could be "unwarranted dilution of stakeholder theory", as it has to be useful to produce guidance for managers (Phillips et al. 2003). Is the frontier between managerial theory and public choices impenetrable? What is the decision-making process regarding the acceptation or reimbursement of new technology if not the questioning of acceptable goals, and the identity and legitimacy of stakeholders that are entitled to expect something from the HCPS? In the world of evidence-based medicine, why is positive rationality found lacking when it comes to making decisions? What are the goals of such a system? And who defines those goals? Who are the "stakeholders"? How are they relevant? And how legitimate is their taking part in the resource allocation process? And how can we expect to improve on the efficiency of resource allocation when "stakeholders" are also involved in the process?

According to a report on Health Technology Assessment (Sorenson et al. 2008), productive and skilled "physicians", "health economists" that act as experts in the economic field, "patient group representatives" supposed to defend the main concerns of persons or "industries" involved in the business side of things, are all equally considered as "stakeholders". More "stakeholders" are needed to ensure the "transparency" of decisions and "to be involved in the acceptance process and implementation of assessment results". They include "beneficiaries" with patient representatives in a position to define what they want for their own sake, physicians and industrialists as performance levers for the HCPS and health-economists seeking to improve on efficiency for the sake of resource allocation, representatives of "stakeholder-citizens" for the purpose of making democratic decisions, and "stakeholder-managers" from an instrumental point of view. But what is the final goal? Effective resource allocation is insufficient when it comes to defining which goals participants should be striving for.

In our opinion, this confusion between "stakeholder-citizens" and "stakeholder-managers" does in itself partly reveal the difficulty or maybe even the impossibility of eliciting -either definitively or in

principle- the goals of the system for pragmatic and ethical reason. It is possible to define general goals as the WHO does, and it is also possible to have a technical approach to very operational objectives for each individual as recently summarized by Porter.

In HCPS operations, a public or private hierarchical authority delegates the decision to allocate resources according to the decision regarding reimbursement to agencies or supervisory bodies whose job it is to rank priorities. They officially use bargaining or rational decision-making based on bio-medical efficiency and cost-effective ratios. But it is far from covering the entire decision-making process governing resource allocation. Deciding who should define priorities for the sake of a community is not a technical but a philosophical question, yet it overlooks the crucial issue of resource allocation within the HCPS and its many stakeholders vying to defend their own interests. Who is capable of choosing between two programmes when one aims to add 10 years to the lives of 100 people and the other aims to add 3 months to the lives of 4,000 people. "Citizen" and "community interests" are all about democracy within the decision-making process.

There are different ways of organizing this sovereignty. In France, we tend to believe that this question is safe in the hands of a public authority, representing the rather obscure notion of a "Republican State", which in French culture means a public authority enlightened by humanistic, democratic and egalitarian values. This has resulted in highly centralized agencies, overwhelmed by such a wealth of strategic plans that any notion of priority seems to have been lost.

Our belief is that no public or private agency can, on its own, guarantee that decision-making will not be appropriated by the most influent, or those with the most bargaining skills, and that local decisions will be consistent with the general instructions given by those agencies. The question is not "who" is most apt to decide for the sake of a community and its individual members, but "how" we can ensure that sufficiently democratic and transparent decisions can emerge from such a complex system. That is not to say that agencies aren't able to set rules, but in the building of rules, procedures and concrete consequences of daily decisions, agencies must first define a regulated decision-making process before deciding to impose substance to the decision that will later be altered to suit local priorities.

How can Stakeholder Theory help? The theory highlights the legitimacy of the maximization of shareholder "model" value and is capable of explicitly addressing morals and ethical values that are considered to be necessary to business. What if we question the legitimacy of such values in a field historically dominated by ethics and those used to address economic constraints? We believe that the different aspects of stakeholder theory, namely the problem of defining the organization's goals, fairness among participants and the legitimacy of expectations are relevant to understanding such a system.

The institutions, actors, and financial systems that supervise the HCPS are structured differently in different countries, ranging from universal coverage systems to private contractor insurance markets,

from mainly publicly supervised providers to free market operators, including specialized companies, mainly dominated by private, not-for-profit organizations. But in our opinion they have the same decision-making process dilemmas.

2) Irreconcilable "hypernorms" and the unavoidable priority-related discussions regarding "macrosocial contracts" that make up HCPS in democratic countries

Despite the breadth of a concept capable of embracing a large range of people, Stakeholder Theory includes a hyper-legitimacy that is seen as a hypernorm, and has consequences on "macrosocial contracts": the shareholder's right of property. Embedded as a Weberian legal rational legitimacy or as a social consensus, it considered the pre-existence of organizational goals before any discussion about resource allocation. When shareholder supremacy is discussed, the main question is not "who" the organization should be serving, but "who else, other than shareholders" should the organization be serving. Yet, when considering the HCPS, the very question of the "macrosocial contract" relies on defining "who" should be served before any other consideration.

There is no such socially accepted hypernorm in the HCPS as "producing economic value" and no room in this business[2] for "sharing the value produced". As is obvious in the WHO definition, the hypernorm concerning well-being is too wide-ranging. As we will demonstrate, it is framed by various considerations that could prove to be real dilemmas when addressed.

Basing our work on the concept presented in the Integrative Social Contracts Theory by Donaldson & Dunfee and its contractualism feature (T. Donaldson & Dunfee 1995) (T. Donaldson & Dunfee 1994) the ISCT distinguishes hypernorms that belong to the field of general philosophy and impose bounds on human activities. They induce implicit "macrosocial contracts" that refer to the classical contractarian theory in philosophy and political economy, framing political decisions within nations or macro groups. Then comes a dense network of "microsocial contracts" that represents the implicit or explicit agreements of members of specific communities and enables different organizations to work together.

What are these "hypernorms" on which "macrosocial contracts" are based? "Patient must come first" is the answer of most doctors, nurses, patients and politicians when asked, consistent with the general hypernorms on which the Hippocratic oath and the WHO are based. But the leitmotiv of a "patient-centred system" is the emotional expression of something that matters most to individuals: staying

[2] We do not believe that such a simple definition covers the diversity of real business, but it solidly frames strategic business management, and the fact that companies exist to create economic value, and that right of property, or the production and distribution of economic value, determines a hyper priority for profit purposes.

alive - and they have no idea what issues deciders may be faced with when restrictions are imposed on the resource allocation process. And this does not help emergency units when faced with two vitally important situations when they are only capable of dealing with one. We will be discussing four of those dilemmas in particular, identified thank to our empirical material. The opposition between "individuals" and "population" will definitely replace the question of "who" by that of "what" when defining stakeholder legitimacy. Then we will be dealing with constituent parts that can be included in "what" is legitimate in the decision-making process: bio-medical priorities versus a multidimensional approach, innovation versus precaution, short term versus long term.

Individual versus population. In the medical decision-making process, doctors are responsible for interpreting a diagnosis, mobilizing their knowledge and assessing risks for every single patient. Evidence-based medicine challenges this individual point of view, while randomising control trials and metanalysis (Davidoff et al. 1995) add a collective dimension, and recommendations to a doctor's individual expertise. Doctors are constantly exchanging and making decisions that take into account their peers' discoveries and opinions (Castel 2005), but promoting an approach aimed at the population and based on statistics, as is the case with resource allocation, is a paradigmatic revolution. When one type of treatment proves effective on 50 people out of 100 and another type is found to be effective on 60 people out of 100, it is logical to assume that the second should be favoured, but there is no way of knowing if the 50 saved by the first programme would have all been included in the 60 saved by the second. So what are the consequences for modern-day patients?

This aspect questions the acceptability of the cost-efficiency ratio based on bio-medical and collective aspects within the "microsocial contract". What would happen if the cost-efficiency ratio of very expensive drug desperately needed by patients was to be taken into consideration? As is the case of this English patient, a 57-year-old man with metastatic renal cancer, who faced the English NICE[3] to argue that a particularly expensive drug had stabilized his disease for more than 2 years, during which he had continued to work full-time. "The quality of life this drug gives me is priceless" he said. But unfortunately, it is not priceless in terms of the common pool resource. Having to deal with often irreconcilable aspects is a very real problem within the decision-making process, as NICE's English Director Michael Rawling, pointed out "… We are not trying to be unkind or cruel. We are trying to look after everybody." (Steinbrook 2008)

Another example: increasing the access of elderly patients with non-cancerous myelodysplastic affections to blood transfusions could help improve their quality of life, but for providers it raises the question of blood availability and the consequences of rising prescriptions if blood donors do not increase. How do you define a collective priority when forced to share limited resources between

[3] NICE : National Institute for Clinical Excellence, an English organization that assesses the feasibility of financing new technology by the National Health Service (NHS), the English collective insurance system

different types of patients (emergency units, obstetrics, cancer treatment, ailments affecting elderly people)? And what are the consequences for individuals or groups that are excluded from treatment?

The opposition between the individual point of view and a collective approach can currently be described through systematic breast cancer screening. Screening is likely to reduce mortality related to breast cancer. A recent literary review by the Nordic Cochrane Group revealed that for 2,000 women invited for mammography screening over a 10-year period, one will have had her life extended and 10 healthy women, who would not have been diagnosed if they had not been screened, will have been treated unnecessarily. Furthermore, more than 200 women will have been subject to high levels of psychological distress over many months due to erroneous cancer detection. It is thus not clear for instance whether screening does more good than harm (Gotzsche & Nielsen 2011), although it is a good thing for women who avoid more severe forms of breast cancer.

Adding up the advantages for a population makes sense in terms of medico-economics, but it is not easily adapted to the individual practice of medicine, and generates particularly acute ethical dilemmas. When two programmes are vying for financing, one that will add 5 years to the lives of 3 people -that is a total of 15 years of human life- the other that will add 10 years to the life of one person, it is difficult to say whether or not the patients and doctors who will be deprived of treatment will see the fairness of such a decision. In the late 1980s, the state of Oregon defined its benefit package aimed at making more people eligible for Medicaid by ranking 700 diagnoses and treatments according to their cost or benefits for the global population. The state legislature then drew a line at item 587 which corresponded to the allocated budget; treatment below that line would not be covered (Bodenheimer 1997). Evidently, heavy medical treatment with high risks of failure and concerning only a small part of the population were ranked at the bottom of the list and not covered through Medicaid. Neither were organ transplants. However, in 1987, the case of a 7 year-old boy who died because he was refused a bone marrow transplant raised questions about this purely collective approach. Such patients would be far luckier if they had ordinary diabetes or breast cancer!

Restrictions in resources to finance the system reveals that "ethics of individual efficiency" might compete with "ethics of efficiency for the health of the whole population" (Maynard 1997) and this is challenging the macrosocial contract supporting HCPS financing systems. Individual patients and patients that are part of a group of patients suffering from the same pathology may be legitimate or not. The real question is: "Legitimate for what?"

Bio-medical priorities versus the multidimensional approach. The HCPS, dominated by modern medicine, could be presented as focussing on science-related dogma (rather than magic), individual concerns (rather than collective), the body (rather than the mind) and technicism (rather than holism) (Bozzini et al. 1981), resulting in the paradigm sometimes called a bio-medical paradigm (Vrancken 1995). Patients are identified according to the individual biological parameters of their disease, by

using evidence-based medicine, and this constitutes normative criteria towards promoting efficient resource allocation (Cochrane 1972) (Drummond et al. 2005). This means that what should matter is not the patient/person himself, but the disease or organ affected by the disease.

This is not to say that the promoters of such an approach are not conscious of people's needs outside medical care. Archie Cochrane, often presented as one of the founder of Evidence-Based Medicine, was a humanist, who spent his entire life as a practitioner among Welsh miners. He was very conscious of medical needs and the scarcity of resources, and did not accept the idea of wasting money on one person when that money could be used to improve the health of the entire population (Cochrane 1972). His vision was not based on an ideology of rational bio-medical medicine, but on a strategic managerial perspective regarding resource allocation. Ultimately, money must be spent in priority on programmes that give the best survival rates. Individual survival is clearly a hypernorm for doctors while the survival of a population is a hypernorm for public deciders dealing with resource allocation.

For cancer patients, the question is particularly acute when there is no hope of a cure; and patients and relatives need more sociological and psychological support than bio-medical care. Efficient care is limited to palliative care and pain management, but curative care such as chemotherapy is sometimes maintained, as patients and doctors want to maintain hope or are simply unable to make a firm decision. Doctors who have to announce the end of chemotherapy treatments have to face emotionally affected patients, and some patients might prefer, as do doctors and families, to pursue unnecessary treatment instead of simply giving up hope (C. Koedoot et al. 2003) (H. de Haes & N. Koedoot 2003). In every day decisions, care providers attempt to allocate resources not only to prolong life, but to provide support to patients and families undergoing very traumatic psychological or social situations. One example is a hospital that footed the bill for a woman living in a caravan in the countryside, to help her rent facilities so that her son could die "at home", as she could not afford the financial cost of spending several days living close to the hospital to be with him. Palliative care exists, but it needs to offer more than survival and be less of a struggle to be included in the HCPS.

As modern medicine now enables people to live with chronic diseases, psychological and sociological issues are becoming a real preoccupation for providers. Bio-medical results for organ transplants are highly successful, but the psychological dimension must also be taken into account as some people have trouble adjusting to the idea of living with someone else's body parts. Since the 1990's, a movement called "patient preference elicitation" has been trying to develop the conditions needed by patients to express themselves when placed in a stressful situation, thus attempting to "shared the decision" between patients and doctors (Coulter 1999) (Moumjid et al. 2007). When a patient insists she would rather not have her breast removed despite the risk involved (n%), although mastectomy would only represent a risk of m<n%, she is merely saying that as far as she is concerned, the social

and psychological distress are more of a threat to her well-being than the bio-medical threat, and challenging the priority given to the survival "hypernorm" when applied to her personally.

But although bio-medical care can be defined and associated with something we are able to measure, such as years of life, other forms of care, such as social and psychological care have no such set boundaries. The question of including them in the collective financing system is more difficult now than ever before, owing to restrictions and the fact that expenses have to vie with increasingly costly technological health innovations.

Innovation versus precaution. The innovation integration process in our societies is making us all schizophrenic. We look to innovation as a last resort to save us from all sorts of dangers, including death. Addiction to innovation is growing, influenced by marketing (Deyo 2002) and based on its expected economic impact (Felt & Wynne 2007). Healthcare is unable to overlook that pressure, as research is urged to find solutions to all life-threatening situations and to urgently apply them to patients, while scientists request deadlines to make assessments that are time-consuming or simply impossible. (Teutsch et al., 2005)

As for the consequences of electronics, we continue to live with uncertainty given that the consensus of the scientific community is that nobody should make a serious hypothesis before we are able to measure changes in diseases in 15 or 20 years' time. Various matters involving chemical and pharmaceutical products have given rise to a strange precautionary principle *after the event* that just goes to show how risk adverse we are after the event. The promises of innovation and new technologies have become a "hypernorm" in our society inasmuch as we are not really adverse to taking risks. We initially oppose resistance, demanding "serious assessment" that cannot be given *a priori*, but we accept that innovation is a risk that has to be taken for the good of humanity.

But medical decision-making is all about balancing benefits and risks. Although risk is largely accepted when lethal consequences are forecast in the short term, the middle or long term effects of some treatments might counterbalance some decisions. Striking a balance between quantity and quality of life is certainly an issue concerning cancer, which is often painful in the final stages. Considering patients receiving chemotherapy, the toxic effects of which is known, the question of long-term consequences is now open, seeing as more and more people are being cured. This brings us to our last point: our "hypernorms" dilemma elicitation.

Short-term versus long-term perspectives. People do not seem prepared to abandon the comfortable technology of mobile phones. Immediate and real advantages versus future consequences are revealing our preference for present versus future. Campaigns undertaken to explain the effects of tobacco on health have partly reduced smoking, but some people remain addicted, knowing full well the risks they are running, seeing as the relationship between tobacco and lung cancer has now been firmly

established. The immediate satisfaction they have of smoking is preferred to the potential impact it will have on their health in the future.

The further prevention requested by the WHO presupposes a preference for the future, whereas humans seem to be widely dominated by a preference for the real and pleasant present, which explains their dangerous behaviour. It is easier to impose stringent care when patients are faced with potentially lethal consequences in the short term. Potentially toxic chemotherapy is accepted despite its side effects, when it offers a chance of survival rather than certain death if nothing is attempted. But concerning some habit-forming treatment, when there is a risk (but no certainty) of recurrence that the drug will attempt to reduce (but not suppress) with potential side effects, the situation is more evenly balanced.

Consequences of the emergence of "macrosocial contracts" It could be said that the dominant consensus that is emerging in the decision-making process plumps for bio-medical/individual/innovation/short term, a position embedded in the cost-effectiveness ratio. But the consensus is often challenged, and the decision-making process can do nothing more but be open to accept divergence, while every decision is liable to violate one of those contradictory "hypernorms". When bio-medical efficiency is ignored by prescribing chemotherapy as a way of supporting final-stage cancer patients, when money affected to technical care is used to finance psychological support, when short-term individual risk is accepted to balance the long-term effect of germ resistance to antibiotics, when particularly innovative care is ignored to finance a prevention programme, dilemmas are handled differently by different decision-makers.

The cost-effectiveness ratio, known to be the best use of every euro spent on health care has become a powerful argument for promoting new health technologies, and is supported by another consensus that is bio-medical/population/innovation/short term. It has grown into a thriving industry (Hollingsworth & Street 2006), while the demand seems to be quite low on the producers' side (Hollingsworth 2008). Beyond the issue of methodology that affects the scientific discussion regarding the real availability of undisputable scientific evidence and despite the useful aspect of this argument in the decision, this norm is not so "socially acceptable". Nothing really guarantees that the general objectives of the HCPS are working and will achieve its general objective to produce more well-being. And it says nothing about the other alternative to resource allocation.

The biomedical approach can certainly benefit resource allocation, but psychological and sociological parameters that escape rational allocation are also important. Just as patients need to be treated with humanity and not only as bio-medical problems, so must the common resource pool be used to deal with individual needs. As great hope has been placed in innovation despite the fact that risk is omnipresent and not always accepted as a consequence of such innovation, preference for the present

is not always compatible with the potential long term effect, but then again life is not just a bio-medical problem.

For sociologist such as Ulrich Beck (Beck 1992) and Antony Giddens (Giddens 1986), "post-modern" societies are having to deal with unstable human frameworks, owing to different factors such as cultural pluralism, the complexity of social organizations or a new conscience of risk and uncertainty. The HCPS is not devoid of such instability, seeing as uncertainty prevails in many situations and scarcity of resources puts the question of efficient resource allocation on the agenda. The decision-making process becomes a reflexive process towards gaining the upper hand on action and making sense of it (Weick 1995) And this means that hypernorms must be discussed and challenged by stakeholders in every decision-making process.

Who can legitimately define priorities and exclusions? The political process can provide a form of democratic legitimacy, but won't solve the problem of the multiple decisions that have to be made within the system. There is no property right here that allows hierarchical decision, and the institutionalisation of key actors appears to be widely insufficient in itself (Sonpar et al. 2010) which means that "stakeholders" have to be included in the decision-making process to produce decisions that make sense and are accepted as such. Management frameworks cannot be based solely on "stakeholder identity", and "who" will be served, but "what" will be served; so more than stakeholder identity, we need to explore stakeholder expectations.

3) From the complex "macrosocial contract" to the consequences of the drawing up of “microsocial contracts": normative or derivative stakeholders’ expectations

Just as those "hypernorms" leave room for discussion regarding "macrosocial contracts", they are also proving a dilemma to “microsocial contracts” and actors have plenty to consider given the wide range of "stakeholder" expectations. Because of these dilemmas, "stakeholder" discussions could be difficult, but the contradictions in the norms that bound rationality cannot be solved without freedom to discuss how such norms can be applied to decision-making. To be manageable, some normative considerations must emerge from the discussion. Not definitely, as it would not be acceptable to choose between those dilemmas, but temporarily, to be able to make acceptable any single decision. One of those discussions focuses on the goals of the decision-making process, both in terms of general philosophical considerations and pragmatics, which have to be evenly balanced and settled in this situation, as something has to go. As the social psychology of fairness suggests, people are concerned about the fairness of the distribution process itself (Greenberg 1990) (Colquitt et al. 2001), and accept poor outcomes in their perspective when the procedure for distribution is thought to be fair (Lind & Tyler 1988). In this perspective, a wide range of stakeholders must be represented in such a context.

Goals that stem from hypernorms often alter according to priorities and allow for more flexibility in the way resources are allocated or appropriated. In addition to hypernorms, the HCPS includes a wide range of interlinked objectives other than life expectancy (ways of measuring created value), such as incomes for doctors and nurses, profit for pharmaceutical companies and even economic growth for countries (both a consequence and condition of the value creating process). Economics and ethics cannot be treated separately.

Resource-based perspectives give the upper hand to some stakeholders managing key-resources, enabling them to reap the benefits of created value while other have little possibility of being able to assess just how much value is bypassing them in the process (Coff 1999). Despite the existence of powerful hypernorms, decisions might be made that disregard the main objectives of the system itself. The process is very efficiently geared in favour of discreetly dominant stakeholders, or those who frankly impose conditions on the decision-making process while overlooking patients, whose ability to assert their claims remain limited (Elms et al. 2002). While many actors might claim their legitimacy, policymakers, and all stakeholders involved are not simply responding to "problems" that exist within the community, but are also actively framing problems (Greenhalgh & Russell 2009) adding a wide range of claims to the final goal of saving years of life. Such dilemmas require that specific goals are defined by the stakeholders themselves, and justified in front of a democratic community.

There is no major ethical consideration needed to organise access to products or services that are not vital for people, such as owning a car or being able to go on holiday, yet giving people access to effective care when they are dying and could be saved by such care is a major problem. Drugs are assessed in the following terms: are they efficient enough to warrant public financing? Lobbying on the part of the pharmaceutical industry during the last influenza pandemic for example, is now considered to have imposed illegitimate expectations. The question of sovereignty does of course belong to political science. But the question of major decisions and trends must be solved, at least partly, before any management process can be launched by the political decision-making process, or by empowering a collective decision-making process made up of legitimate participants (experts, citizens…). Sovereignty is thus partly transferred to the stakeholders in charge of supervising the system, the counterpart being the transparency of decisions.

Focusing on stakeholders in the HCPS's decision-making process is a great challenge for collective resource governance, but without a normative approach, we can only agree with Philips when he says it is a useless approach, seeing as all potential stakeholders have different expectations.

Stakeholders' expectations and the rest of the world. The stakeholders in question can't just supervise a system and decide for the rest of society that expenses simply have to be increased to satisfy their unlimited needs. Those obliged to vie with the HCPS for common resource pools are not stakeholders, but people under potential threat, so that ethics with regard to the rest of the world has

now become the main aim of the closed world of HCPS management. This is very much a current issue, the potentially unlimited and voracious expenses of which will soon be on par with other common resource pools such as education or social expenditure for example. Managers at every level, including key constituents representing insurers or government agencies, must deal with strategic and ethical problems embedded in the decision-making process. A wider normative approach mapping stakeholder expectancy is a necessity, in view of the great influence it has on local managerial practices (Elms et al. 2002). It doesn't intend to replace the deliberative decision-making process necessary to political choices, but to contribute to HCPS management, once decisions have been made by the relevant authorities (public or private insurers or agencies) or to replace decisions that have not been made for some reason or another (the political agenda for example). When capacities are reduced in emergency units owing to political decisions, and doctors have more patients than they are able to deal with, they are obliged to decide who will be treated first and who will not receive treatment. They make their decisions alone and risk being exposed to legal action in the future. It is not ethical to force doctors to be solely responsible for what should be a collective decision regarding priority. One of the consequences of such a situation is that more and more doctors could refuse to ensure emergency services.

Our research attempts to clarify the role of stakeholders, proposing a comprehensive mapping model of the identities, expectations, and perspectives of HCPS stakeholders. We believe that creating more transparency to that end will be more efficient for the decision-making process than the current and usual statement of interest. Phillips suggests that stakeholders may be usefully divided up into normative and derivative stakeholders. "Normative stakeholders are those to whom the organization has a direct moral obligation to attend to their wellbeing. Alternatively, derivative stakeholders are those groups or individuals who can either harm or benefit the organization, but to whom the organization has no direct moral obligation as stakeholders. The organization is not managed for the benefit of derivative stakeholders, but to the extent that they may influence the organization or its normative stakeholders, managers are obliged to account for them in their decision-making. Far from strict equality, therefore, there are a number of more convincing ways that Stakeholder Theory may distinguish between and among constituency groups." (Phillips 2003) We suggest taking stakeholder expectations into consideration as well as stakeholder identity, seeing as we believe the latter is insufficient.

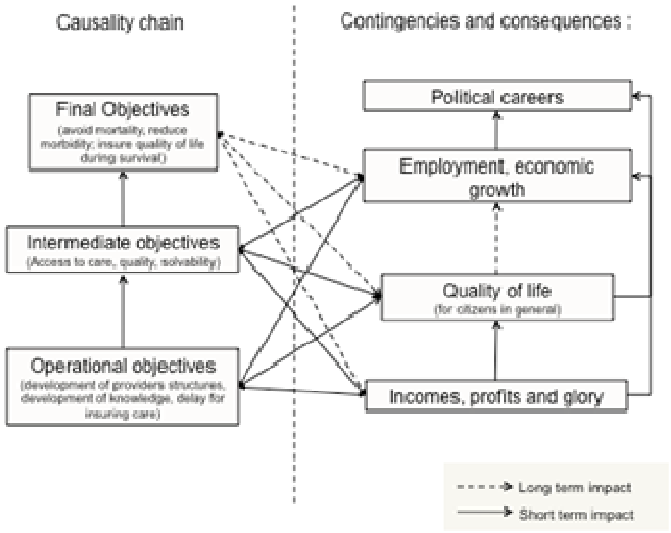
From goals to side effects. What HCPS goals should be considered? The answer is keeping people alive and alleviating their pain when they have a disease or a physical or psychological ailment. This includes "achieving or maintaining health status", "the recovery process" and sustaining health" throughout time (Porter 2010) with regard to the bio-medical aspect, but in some cases it also means maintaining whatever life is possible when no cure is available. Because it is difficult to clearly and

directly measure the effectiveness of care, conceptual frameworks generally include the measurement of intermediate objectives.

Results are therefore mainly oriented towards measuring the efficiency of the processes, like hospital resource availability, delays for treatment or nosocomial infections. These secondary objectives assess the activities involved in the process of achieving ultimate goals. They describe the means to reach the ends, such as the rate of vaccination or the level of access to care, both of which are linked to the final expected outcome, which is to reduce the number of deaths from disease. Most countries use this kind of framework (Arah et al. 2003) to describe the causal chain of objectives.

But they also split into different sub-objectives and side-objectives. For instance, to improve performance, hospitals must organize human resources and develop staff training. Good training is therefore a sub-objective for hospitals. But this increases staff skills, who then expect a better salary as a side-objective. Figure 1 summarizes this aspect. The causal chain, from sub-objectives to final ends of the HCPS, represented on the left side, are known as "normative expectations" and the side-objectives that are contingent to the existence of the causality chain are presented on the right side, and known as "derivative expectations".

Figure 1: Ends and means in the causality chain, contingencies and consequences



In the meantime, representatives who have to manage economic growth, employment and the HCPS, and might simply choose to preserve employment in their region, which would imply that they are defending a local hospital rather than the efficiency of the health system in general.

Private profit-making health providers must satisfy their shareholders' dividend expectations even when short-term profits are a potential threat to long-term health outcomes. This is an inescapable side effect of a private profit-making sector in healthcare provision, just as side revenues (expected by

nurses, doctors, or any other members of staff) are a logical consequence of HCPS staffing requirements. Healthcare by public providers is not exempt from its own side effects, with doctors seeking personal notoriety, or the fact that public hospitals employ a large section of the population in small towns, as is the case in France for example, illustrates just one such contingent objective. Some hospitals may perform poorly in terms of health service performance but may fill a socio-economic mission. Those side-objectives impact the strategies of health service providers (in the sense that they create externalities) and can be viewed as a constraint.

Multiple causality chains complicate the situation, opposing arguments about the effects of causal chains. It is easy to confuse circular causality chains with final outcomes and to point out the counterproductive effects of management measures. The conflicts and trade-offs between the different objectives will not necessarily lead to compliance with health outcome purposes. For instance, the cost-shifting phenomenon (choosing patients who will generate profit rather than those likely to suffer from complications) is a side effect that could have a negative impact on health (Meyer & Johnson 1983). The corollary of this is the risk that side-objectives substitute for secondary objectives, so that the decision may be influenced by an inversion of finalities/externalities. Externalities become a major priority (making money and prosperity through innovation) whereas finalities (improving patients' quality of life in the long term) will be attained later, and too late for assessment. Finalities then become a mere pretext, which may appear legitimate in the short term.

Stakeholders' identity and the legitimacy of their expectations: The consequence of such analysis is that normative and derivative are embedded in the expectations rather than in the identity of a given stakeholder, and must be a part of the managerial approach of decision-making processes.

For the purpose of our demonstration, let's first examine the case of patients. To some extent and according to the current dominant consensus people should not be seen as people but as "shareholders" within the system, considered solely in the light of their biomedical parameters. But as individuals expecting to receive care in order to avoid early death they are also legitimately entitled to expect a certain quality of life. They are derivative stakeholders when extra medical care is required and a collective decision decides not to pay for some of that treatment in favour of another part of the population, the suffering of which is greater or simply because it could be used to treat a greater number of patients. But as we explain below, in so doing they are excluded, and therefore cease to be "stakeholders", when expressing expectations unrelated to the HCPS, like taking advantage of their illness to stop work because they do not find their job interesting, or asking for personal attention that exceeds the capacity of the system in question. For cancer patients receiving terminal care, the question is emotionally expressed by care providers: "How can we say 'no' to someone who is going to die, and continue to care for them, when this is in violation of our 'hypernorm'?" The question that counterbalances that feeling of violating a "hypernorm" is how fairly resources are allocated to other patients who also need them, which is far less discussed with regard to the individual perspective than

the collective approach. To be socially acceptable, a decision has to be fair, and conditions must be transparent.

Close relatives, directly impacted by a patient's disease and care, are subject to increasing demand on the part of the HCPS to be actively involved in patient care, especially in the case of chronic diseases. They have specific expectations, which are different from those of the patients themselves, and considering the part they play, some expectation are normative. For Alzheimer or Muscular Dystrophy for instance, parents and relatives handle the question of care with organizations that collect private funds for research and care treatment to compensate for the lack of a publicly available common resource pool. In some cases, they end up becoming patients themselves due to the distress and disease caused by having to care for patients.

Providers are diverse: doctors, nurses, and other staff in charge of patient care, sometimes working alone, or as part of an institution such as a hospital, pharmaceutical and medical equipment industries or logistic providers such as ambulance workers. As they work within the system and provide care or products for the sake of patients, they are normative stakeholders. But let's take a look for example at the case of pharmaceutical industries seeking to justify high prices for the sake of their shareholders. When do they become derivative for having unacceptable expectations? And what of core skills that are necessary, specific and in some cases scarce, and cannot be done without, and therefore give some providers the upper hand when negotiating resource allocation, as highlighted by the resource-based approach. This obliges managers to take them into account in their decision-making processes, but it remains a derivative interest and the question of what is acceptable and what is not is forever under discussion. Two years ago, and prior to negotiation, the French Minister of Health publicly presented statistics on the rise in doctors' wages over the past years, as a way of obtaining a political advantage in the discussion, arguing that doctors had in no way been wronged during this difficult period. Yet so far, the question of pharmaceutical industries constantly asserting that innovation requires increasing sums of money has not been seriously challenged.

Public authorities, and especially those representing voters, are faced with complex constraints related to economic development, employment and town-and-country planning. With more that 10% of the GDP, they are never completely isolated from the rest of the socio-economic world. But while preoccupation for the public health status of the population makes them normative stakeholders, the expectations they have for socio-economic consequences remain derivative.

And all those involved: patients, close relatives, providers, industrial companies, etc., belong to different socio-economic groups that have their own dynamics. This heterogeneity implies that there are different interests and contradictions within the community that will bring derivative interest to the system, sometimes hidden by their normative legitimacy as patient or providers. Of course, statements

made regarding conflict of interest were an important step, but remain insufficient: "stakeholders" cannot be dealt with in the sole light of their identity; their expectations must also be supervised.

Conclusion:

Diversifying the stakeholders involved, as suggested by Sutton and al, is surely a good point, though it may not be sufficient, in the same way as identifying conflicts of interest is insufficient. Identifying who can decide and defend a final outcome in such a complex relationship of cause and effect is not exactly consensual, as we have shown and far from simple and the decision must surely not be left to the discretion of small-empowered groups, including in some cases public institutions and bureaucratic agencies. By way of a conclusion we believe that whoever is involved in HCPS management will need to be equipped to handle discussions and choices to deal with contradictory "hypernorms" and stakeholders' normative and derivative expectations. Adding more "stakeholders" to decision-making processes will not automatically lead to more acceptable solutions and it could even add more conflict or more situations in which "stakeholders" will be banding up against others. Increasing the number of stakeholders will require even more transparency in the expectations framing discussions.

The existence of dilemmas and contradictions doesn't mean that every citizen is entitled to "help themselves" from the common resource pool that is intended to ensure access to care for all. We believe that mapping expectations thanks to Stakeholder Theory framework is an appropriate way of understanding the internal workings of the process, especially when final outcomes are vying with side objectives, and inversions between final outcomes and intermediate outcomes or side objectives are possible. Introducing more stakeholders implies a new framework of understanding and new cognitive shapes in the decision-making process. It is necessary to "map" the goals of common resource pools on the one hand and stakeholders' objectives and constraints on the other through a normative approach. This suggests re-examining democratic governance processes in the future, to rethink resource allocation decisions and manage available resources and interrelations in a sustainable way, along with their contradictions and expectations and make acceptable sacrifices based on the resource allocation process.

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